STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G596	A. BUILDING 01 B. WING	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER DEVELOPMENTAL SERVICES	1426 S ALVORD LN EVANSVILLE, IN47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/22/11 Facility Number: 001110 Provider Number: 15G596 AIM Number: 100240090 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Rehabilitation Center Developmental Services was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was sprinklered. The facility has a	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	monitored fire alarm system with smoke detection in the corridors, sleeping rooms, and common living areas. The facility has a capacity of eight and had a census of seven at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Impractical with an E-Score of 7.2. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
KS149	Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2 Based on observation and interview, the facility failed to properly use a noncombustible container where cigarette butts can be disposed of for 1 of 1 smoking areas. This deficient	KS149	All group home staff and management will be re-inserviced on appropriate usage of smoke towers. Group Home Manager and Group Home Coordinator will observe smoke towers once per week to	10/04/2011

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	practice could affect all clients while around the back porch area which included the drive way. Findings include: Based on observation on 09/22/11 at 10:20 a.m. during a tour of the facility with the Assistant Home Manager, there was a smoke tower at the back porch smoking area, however, the top portion of the smoke tower was off exposing the bottom portion which contained over 100 cigarette butts with paper and plastic trash mixed together. There were also dried leaves accumulating on the ground in this same area. This was acknowledged by the Assistant Home Manager at the time of observation.		ensure this does not occur.	

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KS152	(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all clients. Findings include: Based on review of the facility's Fire Drill folder on 09/22/11 at 9:30 a.m. with the Office	KS152	All staff will be retrained on the fact that frill drills must be run during the first shift and always at alternating times. The Office Coordinator will monitor this quarterly.	10/04/2011

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	Coordinator present, the facility did have twelve documented fire drills since September of 2010, however, there was no documented fire drill conducted during the first shift (day) of the fourth quarter (October, November, and December) of 2010. This was acknowledged by the Office Coordinator at the time of record review.			